MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** ( ) Yes (x) No
Requestor's Name and Address Dr. B 7125 Marvin D. Love #107 Dallas, TX 75237	MDR Tracking No.: M4-04-3864-01 TWCC No.: ___ Injured Employee's Name: ___
Respondent's Name and Address Federal Insurance Co. c/o Harris & Harris Box 42	Date of Injury: ___ Employer's Name: ___ Insurance Carrier's No.: 023202039630YORK

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
05/01/03	05/01/03	E0235	$473.00	

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary dated 11/14/03 states in part, "…Our charge for date of service 5-1-03 was denied as not documented. We had resubmitted with documentation and again our charge was denied as not documented".

PART IV: RESPONDENT'S POSITION SUMMARY

Per Rule 133.307(i) the insurance carrier response is untimely and will not be considered.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- HCPCS Code E0235 for date of service 05/01/03 denied as "N, 130, 133 – N-Not appropriately documented; Services unsubstantiated by documentation; and See additional information". Per the 1996 Medical Fee Guideline, DME Ground Rule (IX)(A) the health care provider did not submit a statement of medical necessity, along with the order or prescription. The only documentation submitted to support the health care providers position is the clinical for the disputed date of service, which states, "I have given her a paraffin bath unit to use at home as well." Reimbursement is not recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
5/1/2003	E0235	$473.00	$0.00				
				Total Left Column:			$473.00
				Total Amount Due:			$0.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to reimbursement.

Ordered by:

	Marguerite Foster	December 22, 2004
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____